FILE COPY

IDAHO DEPARTMENT OF
HEALTH & WELFARE

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BUREAU OF FACILITY STANDARDS
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February 2, 2010

Thair Pond
Tomorrow's Hope - Meridian
1655 Fairview Avenue, Suite 100
Boise, ID 83702

RE: Tomorrow's Hope - Meridian, provider #13G033

Dear Mr. Pond:

This is to advise you of the findings of the Medicaid/Licensure survey of Tomorrow's Hope - Meridian, which was conducted on January 21, 2010.

Enclosed is a Statement of Deficiencies/Plan of Correction Form CMS-2567, listing Medicaid deficiencies and a similar form listing State licensure deficiencies. In the spaces provided on the right side of each sheet, please provide a Plan of Correction. **It is important that your Plan of Correction address each deficiency in the following manner:**

1. Answer the deficiency statement, specifically indicating how the problem will be, or has been, corrected. Do not address the specific examples. Your plan must describe how you will ensure correction for all individuals potentially impacted by the deficient practice.

2. Identify the person or discipline responsible for monitoring the changes in the system to ensure compliance is achieved and maintained. This is to include how the monitoring will be done and at what frequency the person or discipline will do the monitoring.

3. Identify the date each deficiency has been, or will be, corrected.

4. Sign and date the form(s) in the space provided at the bottom of the first page.

5. Include dates when corrective action will be completed. 42 CFR 488.28 states ordinarily a provider is expected to take the steps needed to achieve compliance within 60 days of being notified of the deficiencies. Please keep this in mind when preparing your plan of correction. For corrective actions which require construction, competitive bidding, or other issues beyond the control of the facility, additional time may be granted.

Sign and date the form(s) in the space provided at the bottom of the first page.

After you have completed your Plan of Correction, return the original to this office by **February 15, 2010,** and keep a copy for your records.

You have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request and all required information as directed in Informational Letter #2007-02. Informational Letter #2007-02 can also be found on the Internet at:

http://www.healthandwelfare.idaho.gov/site/3633/default.aspx

This request must be received by February 15, 2010. If a request for informal dispute resolution is received after February 15, 2010, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during our visit. If you have questions, please call this office at (208) 334-6626.

Sincerely,

MICHAEL A. CASE
Health Facility Surveyor
Non-Long Term Care

NICOLE WISENOR
Co-Supervisor
Non-Long Term Care

MC/mlw

Enclosures

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G033	A. BUILDING _____ B. WING _____	01/21/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOMORROW'S HOPE - MERIDIAN	1821 GREENHEAD MERIDIAN, ID 83642

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	INITIAL COMMENTS The following deficiencies were cited during the annual recertification survey. The survey was conducted by: Michael Case, LSW, QMRP Common abbreviations/symbols used in this report are: PQ - Para-Qualified Mental Retardation Professional	W 000	RECEIVED FEB 16 2010 FACILITY STANDARDS	
W 382	483.460(l)(2) DRUG STORAGE AND RECORDKEEPING The facility must keep all drugs and biologicals locked except when being prepared for administration. This STANDARD is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure all drugs and biologicals were maintained under locked conditions for 7 of 7 individuals (Individuals #1 - #7) residing in the facility. This resulted in the potential for harm in the event individuals accessed and ingested a drug. The findings include: 1. An environmental review was conducted on 1/20/10 from 9:45 - 10:20 a.m. During that time, a can of Equate Athlete's Foot Liquid Spray (an antifungal drug) was noted to be in Individual #2's grooming kit. The grooming kit was located in an unlocked hall closet near the bedrooms, which was accessible to all individuals residing in the facility.	W 382	"W382 Resident's foot spray was locked with other medications as of 01/20/10 Nurse trained all staff on the storage of medication and biologicals. To be kept in Med cupboard. Nurse responsible by 02/01/10 Personal boxes to be checked weekly by Para Q on weekly walk through to ensure footsprays and other topicals are not being stored in resident's personal boxes Para Q responsible by 2/18/10 Weekly walk through to be documented on PSR and reviewed at monthly QA. Para Q and QMRP responsible by 2/18/10	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Thair Pond Administrator		02/10/10

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W 382	Continued From page 1 The PQ, who was present during the review, stated the spray was not supposed to be in the grooming kit, but should have been locked up with other topical drugs. During an interview on 1/21/10 from 9:00 - 9:50 a.m., the Nursing Supervisor stated the spray should have been locked up with the topical drugs in the medication cabinet. The facility failed to ensure all topical drugs were stored under lock and key.	W 382		
W 383	483.460(l)(2) DRUG STORAGE AND RECORDKEEPING Only authorized persons may have access to the keys to the drug storage area. This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure only authorized persons had access to the key to the drug storage area for 7 of 7 individuals (Individuals #1 - #7) residing in the facility. This resulted in the potential for unauthorized persons to access individuals' drugs. The findings include: 1. An observation was conducted at the facility on 1/20/10 from 6:10 - 7:20 a.m. The facility's medication area was observed to be located in the laundry room, which was accessible from both the living area of the facility and the garage. Staff entered the facility for their shift through the garage and entered the living area through the laundry room. During the observation, a staff was noted to assist	W 383	W383 Medication Cabinet keys are now on their own ring which is to be carried by the med certified staff only. Keys are to be exchanged at the shift change and accountibility by handing keys to the next assigned med certified staff. Para Q to assign who is giving meds and who is doing 1/2 hour checks. Para Q responsible by 2/1/10 Weekly spot checks are to be completed by Para Q to assure assigned staff have the med keys. Week checks are to be reviewed at monthly QA Para Q responsible by 2/10/10	

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W 383	Continued From page 2 individuals with self administration of medication. Once an individual was finished taking their medications, the staff would lay the keys to the medication storage cabinets on the dryer and leave the area. Other staff were noted to enter the laundry room, go into the garage through the laundry room, and enter the living area through the laundry room. The medication keys were observed to be unsecured during the following time periods: - 6:15 - 6:30 a.m. - 6:50 - 7:10 a.m. When asked during the observation, the staff assisting individuals with self administration of medications, stated the medication keys were either left on the dryer or in an unlocked cabinet in the kitchen. The staff stated the medication keys also contained the keys to the cleaning supplies. Additionally, at 7:15 a.m., a second staff was noted to take the medication keys and use them to open the cabinet under the kitchen sink where cleaning supplies were kept. When asked during an interview on 1/21/10 from 9:00 - 9:50 a.m., the Nursing Supervisor stated the second staff who was noted to use the medication keys to open the cabinet under the kitchen sink, was not medication certified. The Nursing Supervisor stated the keys should not have been left on the dryer and were not maintained in a secure manner. The facility failed to ensure only authorize persons had access to the keys to the medication storage area.	W 383		

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W 455	483.470(I)(1) INFECTION CONTROL There must be an active program for the prevention, control, and investigation of infection and communicable diseases. This STANDARD is not met as evidenced by: Based on observation and staff interviews, it was determined the facility failed to ensure infection control procedures were followed to prevent and control infection and/or communicable diseases. This directly impacted 4 of 5 individuals (Individuals #2, #4, #5, and #6), and had the potential to impact 7 of 7 individuals (Individuals #1 - #7) residing in the facility. This had the potential to provide opportunities for cross-contamination to occur and negatively impact individuals' health. The findings include: 1. An environmental review was conducted on 1/20/10 from 9:45 - 10:20 a.m. During that time, the following issues were noted: - Individual #2's grooming kit contained an uncovered toothbrush stored with an electric razor, a bladed razor, deodorant, and three containers of body spray. - Individual #4's grooming kit contained an uncovered toothbrush stored with a comb, two containers of deodorant, a can of athletes foot spray, and two bottles of cologne. The PQ, who was present during the review, stated the toothbrushes should have been covered. The facility failed to ensure Individual #2 and Individual #4's toothbrushes were stored in a	W 455	W455 All staff trained on infection control issues regarding appropriate storage of medications and personal hygiene items. Medication bubble packs will be opened with a sterilized opener and wiped clean with a alchoil swab between each medication pass. Para Q and nurse responsible by 2/1/10 Para Q, Q, or nurse to observe medication passes at least weekly to ensure staff are following proper infection control procedures. PSRs are to be completed documenting observations and reviewed at monthly QA. Para Q and Q responsible by 2/18/10	

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W 455	Continued From page 4 sanitary manner. 2. During an observation on 1/20/10 from 6:10 - 7:20 a.m., a staff assisted individuals with self administration of medication routines. While assisting Individuals #4, #5, and #6, the staff was noted to use an un-gloved finger to puncture the protective seal on the back of the blister packs containing the individuals' medications and came into direct contact with the enclosed pills. When asked during an interview on 1/21/10 from 9:00 - 9:50 a.m., the Nursing Supervisor stated staff should not have used an un-gloved finger to puncture the blister packs. The facility failed to ensure individuals' medications were handled in a sanitary manner.	W 455		

Bureau of Facility Standards

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MM412	16.03.11.120.04(m) Furniture and Equipment All furniture and equipment must be maintained in a sanitary manner, kept in good repair, and must be so located to permit convenient use by residents. This Rule is not met as evidenced by: Based on observation, it was determined the facility failed to ensure all furniture was kept in good repair for 3 of 7 individuals (Individuals #4, #6, and #7) residing in the facility. This resulted in individuals' dressers being kept in ill-repair. The findings include: An environmental review was conducted on 1/20/10 from 9:45 - 10:20 a.m. During that time, the following concerns were noted: - The bottom three drawers in Individual #4's dresser fell from the dresser when opened. - Six of the drawers in Individual #6's dresser fell from the dresser when opened. - The two drawers in Individual #7's nightstand, located in the closet, fell from the nightstand when opened. Also, the drawers to Individual #7 dresser fell from the dresser when opened. The facility failed to ensure furniture repairs were maintained.	MM412	MM412 Drawers to be repaired to ensure they do not fall out when opened. All dressers will be inspected during weekly maintenance check of the home. Para Q responsible by 2/10/10 RECEIVED FEB 16 2010 FACILITY STANDARDS	
MM753	16.03.11.270.02(f)(i) Locked Area All medications in the facility must be kept in a locked area(s) except during those times when the resident is receiving the medication. This Rule is not met as evidenced by: Refer to W382.	MM753	MM753 Refer to W382	

Bureau of Facility Standards

Thair Pond Administrator 2/10/10

TITLE (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Bureau of Facility Standards

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MM769	Continued From page 1	MM769	MM769 Refer to W455	
MM769	16.03.11.270.03(c)(vi) Control of Communicable Diseases and Infectio Control of communicable diseases and infections through identification, assessment, reporting to medical authorities and implementation of appropriate protective and preventative measures. This Rule is not met as evidenced by: Refer to W455.	MM769		